Missouri
Mental Health
Transformation Working Group

Initial Work Plan

Approved January 22, 2007

Table of Contents

Background and Overview

In February 2001, President George W. Bush announced his New Freedom Initiative to promote increased access to educational and employment opportunities for people with disabilities. The Initiative also promotes increased access to assistive and universally designed technologies and full access to community life. The President identified three obstacles preventing Americans with mental illnesses from getting the excellent care they deserve:

- Stigma that surrounds mental illnesses,
- Unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance, and
- The fragmented mental health service delivery system.

The President established, through Executive Order, the New Freedom Commission on Mental Health as a key component of the New Freedom Initiative to address the problems in the current mental health service delivery system that allow Americans to fall through the system's cracks. In his charge to the Commission, the President directed its members to study the problems and gaps in the mental health system and make concrete recommendations for immediate improvements that the Federal government, State governments, local agencies, as well as public and private health care providers, could implement.

The Commission's findings confirmed that there are unmet needs and that many barriers impede care for people with mental illnesses. In its *Interim Report to the President,* the Commission declared, "... the mental health delivery system is fragmented and in disarray ... lead[ing] to unnecessary and costly disability, homelessness, school failure and incarceration." It further concluded that the system is not oriented to the single most important goal of the people it serves-the hope for recovery. The report described the extent of unmet needs and barriers to care, including:

- Fragmentation and gaps in care for children,
- Fragmentation and gaps in care for adults with serious mental illnesses,
- High unemployment and disability for people with serious mental illnesses,
- Lack of care for older adults with mental illnesses, and
- Lack of national priority for mental health and suicide prevention.

The Commission attributed the shortcomings of the system to problems derived principally from the manner in which the Nation's community-based mental health system evolved over the past four to five decades. They concluded that the Nation must replace unnecessary institutional care with efficient, effective community services that people can count on and that programs that are fragmented across levels of government and among many agencies need to be integrated.

Based upon an extensive review of literature and public input, the Commission concluded that traditional reform measures would not be enough to meet the expectations of consumers and families. To improve access to quality care and services, the Commission recommended fundamentally transforming how mental health care is delivered in America. The Commission established 6 key goals to transform the Nation’s mental health system. A summary of the goals and recommendations are included in the following table.

Goals and Recommendations

In a Transformed Mental Health System ...

Goal 1	**Americans Understand that Mental Health Is Essential to Overall Health.**	
	Recommendations	1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention. 1.2 Address mental health with the same urgency as physical health.
Goal 2	**Mental Health Care Is Consumer and Family Driven.**	
	Recommendations	2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance. 2.2 Involve consumers and families fully in orienting the mental health system toward recovery. 2.3 Align relevant Federal programs to improve access and accountability for mental health services. 2.4 Create a Comprehensive State Mental Health Plan. 2.5 Protect and enhance the rights of people with mental illnesses.
Goal 3	**Disparities in Mental Health Services Are Eliminated.**	
	Recommendations	3.1 Improve access to quality care that is culturally competent. 3.2 Improve access to quality care in rural and geographically remote areas.
Goal 4	**Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.**	
	Recommendations	4.1 Promote the mental health of young children. 4.2 Improve and expand school mental health programs. 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies. 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.
Goal 5	**Excellent Mental Health Care Is Delivered and Research Is Accelerated.**	
	Recommendations	5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses. 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation. 5.3 Improve and expand the workforce providing evidence-based mental health services and supports. 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.
Goal 6	**Technology Is Used to Access Mental Health Care and Information.**	
	Recommendations	6.1 Use health technology and tele-health to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations. 6.2 Develop and implement integrated electronic health record and personal health information systems.

In 2005, RFP's were released by the Center for Substance Abuse and Mental Health Services Administration and seven states were awarded 5 year infrastructure grants to support state level

transformation. In 2006 two additional awards were made, based upon the original proposals submitted, including one to Missouri. A key factor in the award to Missouri was the progress made to date in system transformation and cross-agency collaboration, notably the creation and initial implementation of the Comprehensive Mental Health Plan for Children mandated through SB1003.

Missouri's transformation grant proposal builds upon the work to date and establishes an organizational structure and framework for developing and implementing Missouri's first ever Comprehensive Mental Health Plan that addresses the entire lifespan and transcends state department and other organizational boundaries.

Purpose & Vision

The primary purpose of the Transformation Working Group (TWG), as established by Executive Order 06-39 is to lead the development and implementation of Missouri's first Comprehensive Mental Health Plan that spans state department and other organizational boundaries. The principle charge to the TWG, as outlined in the Executive Order, is to transform Missouri's mental health system to be more efficient and effective in it's delivery of services to Missouri's citizens in the following ways:

- Conduct a thorough state-wide needs assessment,
- Develop a comprehensive state mental health plan,
- Identify and implement policy, organizational, and financing changes required to effectively carry out the state plan,
- Coordinating policy actions with other state and federal initiatives and fully incorporating the Comprehensive Children's Mental Health Services Plan into all planning activities,
- Establishing cross-departmental management teams to address specific policy areas, address specific transformation planning objectives, and implement policy decisions;
- Eliminate redundancies in the provision of mental health and behavioral health services to children, adults and families.

In Missouri's grant proposal it was determined that, to transform the mental health system, Missouri needs to move:

- ***From*** a disability model ***to*** a public health model of service
- ***From*** system fragmentation ***to*** appropriate consultation, collaboration and integration
- ***Toward*** balanced public-private system capacity and local-state system ownership and investment
- ***Toward*** full implementation of evidence-based practices and a culturally competent and responsive system
- ***Toward*** equal access and a state-wide consumer and family voice
- ***Toward*** the advancement of technology to accelerate and sustain transformation

Missouri's proposed vision of a transformed system is broad as it supports all three DMH division populations served:

> ***Communities of Hope*** throughout Missouri support and sustain a comprehensive, integrated mental health system where promoting mental health and preventing disabilities of Missourians is common practice and people are free to live their lives and pursue their dreams beyond the limitations of mental illness, developmental disabilities and alcohol and other substance abuse disorders.

The TWG identified the following elements of what would "look different" in a transformed system as a starting point to its work:

- Resiliency & Recovery will be guiding principles

- Consumers will direct their own care
- Services will support prevention *and* treatment
- Disparities will be eliminated
- We will move science to service faster and more effectively
- Services and supports will be available, accessible, and coordinated
- Consumers will access a "quiet" system (involved bureaucracy will be transparent to consumers)
- There will be no wrong door across agencies
- Healthy, productive citizenry – People with mental health needs will be contributors and receivers of the community
- Complacency will have bee thrown out the window
- Disparities will have been eliminated and more people will be employed
- We will understand the resources we have, and will have organized the system to maximize the value. We will be able to provide more services and better outcomes by better organizing the system and its resources
- There will be an end to turfism (we're all in this together) – Collaboration, not just cooperation
- Things will happen more quickly for clients
- Local, state, and federal levels will all be working better together
- All potential caregivers in the system can assess the full needs of consumers and refer them to the right place
- Consumers receive the same quality of care regardless of income, geography, race, etc. (what you pay may be different)
- Stigma is eliminated
- Consumers and families will be involved in providing services
- The whole state will be competent in disaster preparedness

The above serves as a starting point for the planning and implementation process and will serve to guide the work ahead. Throughout the planning process it will be incumbent upon the members of the TWG, workgroups and advisory committees to:

- Develop and maintain **sponsorship** of the process through frequent communications that are **fact-based and data-driven** with governmental, community and mental health care stakeholders whose support and mobilization will be critical to long-term success.

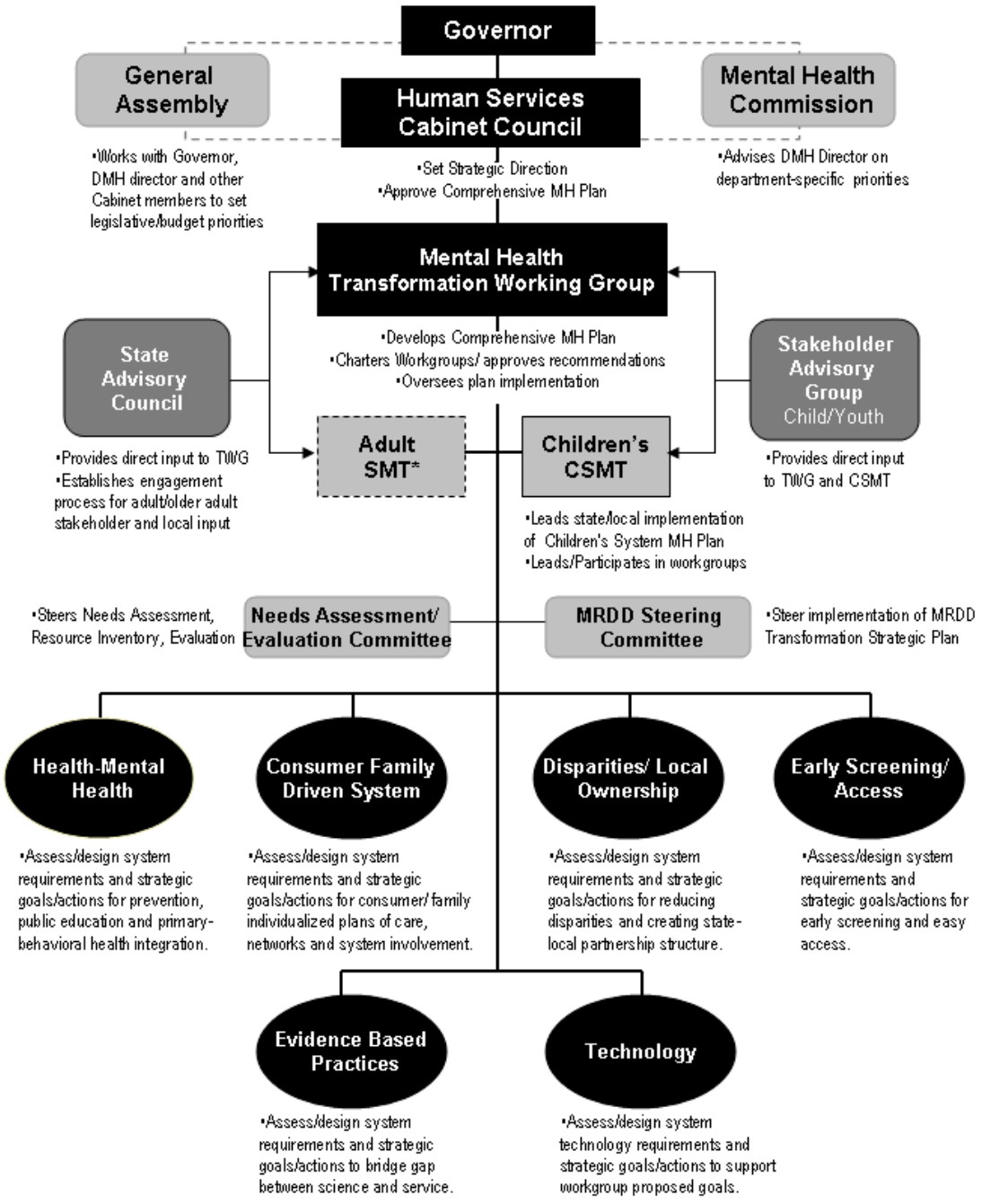
- Communicate the **sense of purpose and urgency** needed for real transformation and maintain a **disciplined approach** to accomplish the vast amount of work within the required timeframes.

- Facilitate **collaboration** and **open and honest dialogue** between workgroups, staff and external stakeholders necessary to break down organizational silos and other barriers to effective change.

Organizational Structure and Roles

The proposed organizational structure of the mental health transformation initiative is depicted in the following organizational chart and further described below.

Proposed Mental Health System Transformation Structure



* Management structure for Adult/Older Adult system implementation to be considered upon plan completion

The Governor has established two principle bodies, the ***Human Services Cabinet Council*** and the ***Transformation Working Group***, with primary membership of the senior leaders from designated state departments, to lead the mental health system transformation effort. In addition, the ***General Assembly*** plays a critical role relative to the development and implementation of the comprehensive plan. The General Assembly leadership will receive regular updates on the planning process and work with the Governor, the DMH Director and the other Cabinet Council members to establish legislative and budget priorities and actions. Also, the ***Missouri Mental Health Commission***, a 7 member body appointed by the Governor, provides policy advice and direction to the DMH Director. The Mental Health Commission will also receive regular updates and advise the department on policy priorities. In addition, Commissioners may serve as "honorary"chairs of workgroups, providing guidance and support to the working chairs through regular communications and progress reports.

In addition to the above bodies, certain interdepartmental workgroups, steering committees and advisory councils will be fully integrated to the planning structure and process and additional workgroups will be chartered around specific topic areas. Outlined below is a description of the purpose and proposed roles of each group.

Human Services Cabinet Council (HSCC):
The Governor has designated a subgroup of his Cabinet to serve as the Governing Body of the Transformation Working Group and steer the mental health transformation process. The HSCC is chaired by the Governor's Chief of Staff. Members include the Directors of the Departments of Mental Health (DMH), Social Services (DSS), Health and Senior Services (DHSS), Elementary and Secondary Education (DESE), Corrections (DOC) and Public Safety (DPS). The principle role of the HSCC is to:

- Establish the strategic direction of the process across departments;
- Facilitate alignment and coordination with other Governor and departmental priorities, and with other branches of government; and
- Serve as the final approval body of the Comprehensive State Mental Health Plan.

Transformation Working Group (TWG):
The TWG is a governor-appointed board established through Executive Order 06-39 that is comprised of key governor office and departmental senior leaders, consumer and family leaders, and other public leaders. The chairpersons and principle staff are organizationally positioned within the DMH to lead the planning process in partnership with other adult and child-serving agencies involved in mental health services. The principle responsibility of the TWG is to 1) create a Comprehensive Mental Health Plan for Missouri that transcends state department boundaries and fully integrates the current Comprehensive Children's Mental Health Plan; and 2) lead the implementation of the plan once developed. In order to achieve this task, the roles of the TWG will evolve across the course of this process to include:

- Coordinate and/or integrate the activities of the TWG with other Governor, state department, legislative and judiciary initiatives;
- Initiate dialogue, seek input and engages stakeholders;
- Serve as the chartering authority for specific workgroups and deploy staff, as appropriate to work on key TWG committees;
- Propose and recommend changes to the current system, develop priorities and coordinate areas of focus for action;
- Build support for the changes proposed through communication, education and organizational support and commitment;
- Mobilize and coordinate resources for achieving the plan once developed; and
- Develop vehicles for measurement and communication of success on a long-term basis.

Children's Comprehensive System Management Team (CSMT):
SB1003 mandated that the DMH, in partnership with all child serving departments, develop a unified, comprehensive children's mental health system. This legislation required the DMH to establish a Comprehensive System Management Team responsible for developing and implementing a comprehensive mental health plan for children. The inception of the mental health system transformation initiative moves the responsibility for plan and policy development to the TWG and HSCC. This addresses one of the key short-term goals of the current children's comprehensive plan "to create a formalized structure for policy and decision-making across departments at the cabinet level". The CSMT will receive principle policy direction from the TWG and will maintain responsibility for implementation of the children's comprehensive plan. The roles of the CSMT include:

- Develop and implement cross-departmental work plans for identified goals and strategies,
- Assist in the development of local system of care infrastructures and provide technical assistance and policy direction to local system of care policy teams;
- Coordinate activities across departments at the state and local levels;
- Build support for the changes proposed through communication, education and organizational support and commitment.

Children's Stakeholder Advisory Group (SAG):
SB 1003 also required the DMH to establish a stakeholder advisory committee to provide input to the CSMT to assist the departments in developing strategies to ensure positive outcomes for children. The SAG membership requires a majority of family and youth representation. With the incorporation of children's policy and planning to the TWG, the SAG will assume a principle advisory role to both the TWG and CSMT. The roles of the SAG will include:

- Provide constructive input and feedback to the TWG & CSMT regarding transformation activities relating to children and families;
- Provide direct input to initial ideas and draft plans of the workgroups and TWG;
- Provide recommendations for final plan approval prior to submission to HSCC; and
- Serve as a vehicle for dissemination of information to key children's system stakeholders in the broader community.

Adult Comprehensive System Management Team:
Currently there is no equivalent CSMT infrastructure in place for adults and older adults. The need for an equivalent cross-organizational implementation infrastructure will be evaluated as part of the overall planning process.

CPS State Advisory Council (SAC):
The State Advisory Council is comprised of 25 members who advise and make recommendations to improve the system of care in mental health. The Council membership is required by federal law to have a majority of mental health consumers, including parents of children receiving services and family members. The SAC will assume a principle advisory role to the TWG. The chair of the SAC will serve on the TWG and the roles of the Council will include:

- Provide constructive input and feedback to the TWG regarding transformation activities;
- Provide direct input to initial ideas and draft plans of the workgroups and TWG;
- Serve as a vehicle for dissemination of information to key system stakeholders in the broader community and work with the chairs of the TWG to establish an engagement process for adult and older adult stakeholder groups and DMH cross-divisional advisory bodies to provide input,
- Establish an engagement process for local input including hosting regional town hall meetings.
- Provide recommendations for final plan approval prior to submission to HSCC.

Workgroups/Steering Committees:
Given the complex analysis and planning required to create an effective comprehensive plan, the TWG will charter workgroups around the six goals of the New Freedom Commission report (See Appendix II for workgroup charters). Each workgroup will be responsible for conducting the primary analyses and creating recommended goals/strategies specific to their focus area. Workgroup membership will include representation from relevant state departments and other public offices, consumer and family members, provider and advocacy organizations and other stakeholders with special expertise or interest. Each workgroup will have at least one DMH leader to serve as co-chair and other DMH staff/consultants assigned to staff the group. A member of the needs assessment/evaluation team and technology workgroup will provide membership across workgroups with responsibility for integrating the work of their teams into the scope of each workgroup. The members of all workgroups will coordinate and manage the planning process with the TWG staff and consultants as directed by the TWG.
The work groups initially chartered will include the following:

Mental Health is Essential to Overall Health: The purpose of this workgroup will be to assess and design state-wide system requirements and recommend strategic goals/actions for prevention, public education and primary health-mental health service integration that will result in *mental health being recognized as essential to overall health*.

Consumer & Family Driven System: The purpose of this workgroup will be to assess and design state-wide system requirements and strategic goals/actions for developing consumer and family directed individualized plans of care, consumer and family networks and consumer and family meaningful involvement in all aspects of system planning, evaluation and service delivery that will result *accountability to consumers and families being embedded throughout the mental health system*.

Disparities are Eliminated: The purpose of this workgroup will be to assess and design state-wide system requirements and strategic goals and actions for reducing cultural and geographic disparities, reducing disparities in housing and employment opportunities, and creating a balanced state-local investment and ownership in the mental health system that will result in *access to the same quality services and community supports/opportunities regardless of cultural differences or geographic location*.

Easy Early Access: The purpose of this workgroup will be to assess and design state-wide system requirements and strategic goals/actions that will result in *easy and early access to the most appropriate level of service across the state* including diversion from unnecessary hospitalization, out-of home placement and incarceration.

Evidence-based Practices: The purpose of this workgroup will be to assess and design system requirements and strategic goals/actions to bridge the science to service gap including workforce development strategies that will result in *excellent services delivered by competent staff*.

Technology: The purpose of this workgroup will be to assess and design system technology requirements and strategic goals/actions to support workgroup proposed system infrastructure requirements and goals/actions that will result in *information and technology that supports individualized quality services and supports*. A member of the technology workgroup will be assigned to each of the other workgroups to assure effective integration.

The chairs of the chartered workgroups will be required to provide regular progress reports to the TWG specific to their scope of work to include recommended strategic goals and actions. Workgroup efforts will be coordinated across workgroups and with other relevant taskforces and committees. Recommended goals and actions should include a rationale for change, outcome

measures and address alignment and enabling capabilities across the following ***dimensions of transformation***:

- **Concepts**: structured approaches to expressing how a course of action might be accomplished for current or future systems, supports and services.
- **Organizational Design:** the change in an organization's division of labor that may be needed to implement a desired course of action.
- **Capabilities:** Techniques, tools and systems that may be required to implement a specific course of action.
- **Authorities:** changes in public laws or regulations that may be needed to provide authority, permission or capabilities to implementation.
- **Processes:** changes in steps, tasks or procedures needed to implement concepts or apply capabilities.
- **Culture:** understandings, beliefs, practices that define and shape operational decisions, organizational responses, and human reactions to change.

In addition to the chartered workgroups, the cross-departmental **MRDD Transformation Steering Committee,** responsible for implementing the division's current strategic plan for transformation, will be incorporated to the transformation structure. The development of the comprehensive plan will incorporate and support the division-specific planning. Also, a **Needs Assessment/Evaluation Committee** will be established to guide the needs assessment and evaluation activities of the initiative conducted by the Missouri Institute of Mental Health.

Proposed Approach, Deliverables and Timelines

The following table outlines the proposed approach, deliverables and timeframes for completion of the comprehensive plan.

Phase	Timeline	Steps	Deliverables
Start-Up	**November 2006 – February 2007**	• **TWG Leadership Team Appointments** • **Development and approval of TWG Work Plan** • **Charter and form workgroups** • **Orient Workgroups**	• **Leadership Team appointments** • **Work plan Charters** • **Team-specific data reports** • **Requests for additional data**
Develop Conceptual / Strategic Action Plan	**February – July**	• **Understanding what success looks like** • **Situation Analysis** • **Idea Generation** • **Development of prioritized recommendations** ▪ **Key requirements** ▪ **Conceptual Designs** ▪ **Identify potential financing mechanisms** ▪ **Presentation of Recommendations to TWG**	• **Gap Analysis Documents** • **Idea Worksheets** • **Prioritized recommendations** • **Presentations**

Integration to Comprehensive Plan	**July – December**	• **Review of workgroup recommendations** • **Prioritize and integrate to Draft Comprehensive Plan** • **Gather public input on Draft Plan** • **Identify key FY09 Legislative / budget priorities (by September)** • **Preliminary / Final Plan approvals by HSCC** • **Submit plan to SAMHSA** • **Roll Strategic Plan into Implementation Plan**	• **Draft Comprehensive Plan** • **Public Input Plan** • **Public Input Notes** • **Updated Comprehensive Plan** • **Presentation to HSCC and other bodies** • **Presentation to SAMHSA** • **Implementation Plan**
Implementation		• **Develop Implementation Teams** • **Charter Implementation Teams** • **Implement** • **Establish Review Cycle**	• **Mgt commitments** • **Charters** • **Review Protocol and Schedule**

Needs Assessment & Inventory of Resources

The Missouri Institute of Mental Health is responsible for conducting a comprehensive state needs assessment and inventory of resources as well as the overall evaluation of the initiative in accordance with all grant requirements. It is important to note that the process to complete the needs assessment and inventory of resources is one that runs parallel with the planning process. MIMH staff will serve on each workgroup to assure data needs are met. The full draft needs assessment and resource inventory will be completed by July 31, 2007 to guide the initial draft plan of the TWG and the final report will be completed, presented to the TWG, and submitted to SAMHSA by September 30, 2007.

The following represents the steps and timelines for completion of the needs assessment and inventory of resources.

Needs Assessment:

1. MIMH to complete epidemiological analysis. Data to include:
    - General population statistics
    - Prevalence of mental illness statewide (overall statistics) and comparisons with national averages
    - Prevalence of different types of mental illness
    - Prevalence of co-occurring disorders

Draft report to committee: January 31st.

2. MIMH to review all existing documentation and write report documenting current needs as articulated in these reports and gaps in information. Special populations to be examined include:
    - Youth transitioning to adulthood (18-21 year olds)
    - Elderly (especially nursing home population)
    - Minority groups (African-Americans, Hispanics, Asians, Bosnians, etc.)
    - Homeless
    - Veterans
    - Deaf and hard-of-hearing
    - Visually impaired
    - Medicaid population
    - Rural populations

    Report to committee by February 29th. Report to include recommendations for primary data collection if different from original proposal.

3. MIMH will interview or conduct on-line survey of TWG members regarding perceived needs and resources. **Interviews to be completed by March 31st.**

4. MIMH to conduct focus groups with specific consumer subgroups as identified through the secondary data collection phases. **Focus groups to be completed by May 31st.**

5. MIMH to conduct statewide survey of mental health agencies to assess needs. **Survey to be completed by May 31st.**

6. MIMH to work with subgroups to assure data needs are met. **Ongoing.**

7. Draft needs assessment report to DMH: **July 31, 2007.**

8. Final needs assessment report to DMH: **September 30, 2007.**

Resource Inventory:

1. MIMH to review all existing documentation regarding resources and provide report to state regarding needs for primary data collection. **Date completed: February 29, 2007**

2. MIMH to review workforce assessment data currently available for gaps in Knowledge; this information will be brought back to the needs assessment workgroup for discussion of next steps. **Date completed: March 31, 2007**

3. MIMH to survey (either in person or on-line) directors of statewide agencies regarding existing resources and resource gaps. **Date completed: April 30, 2007**

4. MIMH to conduct an inventory of all agencies/persons involved in mental health in the state ("asset mapping"). Resources and needs to be mapped geographically using GIS software. **Date completed: May 31, 2007**

5. Draft of Resource Inventory (to be included in Needs Assessment Report) **Date completed: July 31, 2007.**

6. Final First Year report **Date completed: September 30, 2007.**

Evaluation:
An evaluation of the short-term and long-term effectiveness of the plan will be conducted in accordance with requirements established by SAMHSA. Evaluation will incorporate Missouri specific measures related to achieving the six goals as well cross-state evaluation measures under the direction of SAMHSA. A logic model and protocols are being established to direct the evaluation activities. Regular reports will be provided to the TWG to guide future plan activities.

Communications

The Governor, HSCC and TWG are committed to assuring a transparent planning process that regularly apprises the public of the goals and progress of the various workgroups and garners input and feedback from interested stakeholder groups. All TWG and chartered workgroup meetings will be open to the public. Work plans, membership listings, meeting schedules and workgroup proceedings will be posted to the DMH Office of Transformation website and accessible from the Missouri Boards and Commissions Transformation Working Group website. Public feedback will be solicited on all draft recommendations. Staff will be available to speak with key stakeholder groups.

Appendices

Key Definitions & Acronyms

Consumer typically refers to the primary recipient of services. For the purposes of this plan, consumer is defined broadly to address the roles one may play across his/her lifespan and the type of services he or she may require. Thus, consumer may be used to describe any of the following: children, youth, adults; families of origin (parents or siblings) and extended family (grandparents, aunts, uncles, etc.) involved in the care of an individual; and guardians.

Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses - and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments. Closely-knit communities and neighborhoods are also resilient, providing supports for their members.

Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.

Procovery refers to "attaining a productive and fulfilling life regardless of the level of health assumed attainable."

ADA	**Division of Alcohol and Drug Abuse**
CMHC	**Community Mental Health Center**
COSP	**Consumer Operated Service Programs**
CPS	**Division of Comprehensive Psychiatric Services**
CSMT	**Children's Comprehensive State Management Team**
DESE	**Missouri Department of Elementary and Secondary Education**
DHSS	**Missouri Department of Health and Senior Services**
DMH	**Missouri Department of Mental Health**
DOC	**Missouri Department of Corrections**
DPS	**Missouri Department of Public Safety**
DSS	**Missouri Department of Social Services**
EBP	**Evidence Based Practice**

FQHC	**Federally Qualified Health Center**
HSCC	**Human Services Cabinet Council**
MIMH	**Missouri Institute of Mental Health**
MRDD	**Division of Mental Retardation & Developmental Disabilities**
OSCA	**Office of State Court Administrators**
SAC	**State Advisory Council**
SAG	**Children's Stakeholder Advisory Group**
TWG	**Transformation Working Group**

Transformation Working Group
Team Charter
Mental Health is Essential to Overall Health Workgroup

Current Situation

- Targeted prevention efforts have been successfully initiated (e.g., Suicide Prevention Program, Strategic Prevention Initiative for substance abuse, Bright Futures-Promoting Resiliency) however Missouri has not developed a more comprehensive public health mental health prevention approach and prevention efforts are not currently integrated or coordinated.
- Stigma continues to be a barrier to accessing mental health care and anti-stigma interventions are not planned or coordinated.
- The DMH Office of Disaster Readiness provides preparedness education and time-sensitive, frontline psychological response to critical events, however training is often "just in time" and resources are limited.
- Persons with mental illnesses die 25 years earlier, on average, than the general population mostly due to chronic medical illnesses related to modifiable risk factors such as obesity, smoking and inactivity.
- Although poor physical health outcomes, including premature death have been documented for persons with mental illnesses, the vast majority of primary care and behavioral healthcare services are neither integrated nor coordinated. However, the following initiatives constitute a starting point:
    - The Coalition of Community Mental Health Centers is engaged in ongoing discussions with the Primary Care Association to facilitate formation of partnerships to develop local collaboration and integration between individuals CMHC's and FQHC's.
    - Missouri has implemented a Medical Risk Management Project that identifies 2000 persons who have schizophrenia and complicated medical condition and provides treatment summaries and evidence based recommendations for medical and behavioral healthcare.
    - Medicaid's CyberAccess initiative provides summary information regarding diagnoses, outpatient visits, hospitalizations, and medications to enrolled providers. The DMH is currently in the process of enrolling providers to use the CyberAccess tool to assist them in facilitating their clients' primary care needs being met.

Desired Outcomes

- A comprehensive prevention plan promoting public mental health which will focus on risk and protective factors and build resilience across the lifespan. Evidence-based Interventions will be provided at the earliest ages/developmental phases possible.
- Prevention services of behavioral health are infused with overall health and prevention initiatives are coordinated and integrated to the extent feasible in order to achieve economies of scale and broader distribution of prevention interventions.
- Coordinated and integrated disaster preparedness and response efforts with a greater number of community providers and citizens knowing how to prepare and respond to behavioral health needs of the community after a disaster.
- Coordinated and integrated stigma reduction efforts with increased community understanding and acceptance of mental health issues and increased opportunities for consumers to find employment, housing, social activities and treatment as needed.
- An increased number of persons with mental illnesses will receive wellness interventions to engage in physically healthy lifestyles (e.g.; physical activity, smoking cessation).
- A smaller portion of persons receiving primary care will have undiagnosed and/or untreated mental illnesses.

- A smaller portion of persons receiving mental health care will have undiagnosed and/or untreated medical illnesses.
- More clinical settings will provide primary care and mental health care at the same location.
- All community mental health centers and federally qualified health centers will have formal partnership arrangements to provide integrated care.
- Reduction of excess morbidity and mortality related to mental illness, substance abuse and developmental disabilities.
- A decrease in Missouri's suicide rate and substance abuse rates.

Undesired Outcomes:

- Fewer persons seeking treatment for their mental illness due to belief that mental illness is shameful or the treatment is ineffective.
- Lack of or loss of community support for assuring access to effective prevention interventions and mental health treatments.
- A lack of preparedness and response to assist Missouri's citizens with the emotional reactions in the aftermath of a disaster or terrorism event.
- Poor physical health outcomes due to untreated mental illness including premature death.
- Poor mental health treatment outcomes due to untreated medical illnesses.
- Increased physical healthcare visits and cost due to undiagnosed/untreated mental illness.
- Increased rates of suicide and substance abuse.

Scope:

- Statewide and across agencies—i.e., entire system of care; think long term & short term.
- Culturally sensitive, trauma-informed, recovery/resiliency oriented and address the lifespan
- Identify prevention, anti-stigma and mental health disaster preparedness initiatives across all state agencies. Linkage and participation with SAMHSA and other federal initiatives.
- Focus on provision of evidence-based prevention at earliest age/developmental stage possible. Focus on primary and secondary prevention strategies.
- Development of infrastructure proposal for integrated evidence-based prevention.
- Use Medicaid reform to promote/facilitate primary care/behavioral healthcare integration.
- Develop incentives for co-locating primary care and mental health services in the same clinical setting.
- Expand disease management initiatives that simultaneously address medical needs and mental health needs of complicated patients.
- Assessment and acquisition of funding necessary to support public mental health model and integrated primary care and behavioral healthcare.
- Development and use of measurable outcome indicators.

Team Members:

- DMH Medical Director, Prevention Director, Disaster Preparedness Coordinator and Public Information Coordinator
- Person skilled in social marketing campaigns
- School /Early Childhood representatives
- DMH Divisions including Facility representatives, Missouri Institute of Mental Health (MIMH)
- Other State Departments /Government Branches
- Fiscal/budget representative
- Consumer and Family Representatives
- Provider and Community Organization Representatives

Resources:

- Suicide Prevention Grant; Strategic Prevention Framework State Incentive Grant

- Commitment of members' time for meetings; estimated twice monthly for half day up to six months and periodic follow-up through year end
- DMH/MIMH staff support; support from Technology work group

Transformation Working Group
Team Charter
Consumer and Family Driven Services Workgroup

Current Situation:

- Findings from the New Freedom Commission, as well as from DMH focus group research, indicate consumers and families currently do not control their care.
- Missouri lacks meaningful involvement of consumers in the treatment process and consumers/ families do not typically lead the development of their individualized plan nor direct their services. Providers often have a paternalistic view toward consumers.
- There is inconsistent consumer involvement in planning state mental health initiatives and little involvement in evaluating the delivery of mental health services. Currently no structure or mechanism for ongoing, meaningful consumer and family directed policy and program development exists.
- Missouri lacks organized networks through which consumers have access to education, training, networking opportunities, and peer to peer or family to family support services.
- Much recent work has been done to enhance consumer protections and safety (Mental Health Commission Report and Lt. Governor's Task Force), however responses to violations of consumer rights are often inconsistent.
- Consumer Operated Service providers have not been integrated into the continuum of community care as an evidence based practice in Missouri.
- Procovery is a promising practice that has yielded some initial positive results but is not yet integrated throughout the system or across lifespan.
- Conflicting values and goals among state agencies have made it difficult to align practices across agencies that support recovery and consumer choices resulting in fragmentation of services.
- Individual plans of care are inconsistent and do not support transition or coordination across settings (e.g., institutional vs. community) and agencies nor transitions across lifespan (e.g., transitional youth). DMH has not integrated Systems of Care practices statewide.

Desired Outcomes:

- Consumers and families direct and control their services and lead the development of their individual plans of care.
- Providers support the consumer during the development of a plan of care and the supports he or she requires to make successful transitions from institutions to community settings, across agencies and across the lifespan.
- Consumers experience meaningful involvement in planning state mental health initiatives, in providing mental health services, and in evaluating those services.
- DMH development of integrated Systems of Care across the state.
- Consumer roles are expanded by including them in additional roles such as evaluators and trainers.
- Consumer Operated Service Programs (COSP) become part of the continuum of community care in Missouri as evidence based practice.
- Procovery circles are available statewide and across lifespan.
- Consumers receive the supports and services they need to succeed in school, work and the community as measured by the goals they set for themselves.
- Consumers experience increased acceptance by employers, providers, school personnel, and community members.
- The multiple state agencies who serve mental health consumers share a common set of principals and values regarding their care.

Undesired Outcomes:

- Increased provider resistance that derails process.
- Increased non-constructive conflict among groups representing consumers.
- Continuation of the current situation.
- Concerns over Medicaid billing and other professional demands override the peer support values and outcomes.
- Mental health providers fail to hire consumers trained as peer to peer or family to family support workers.
- Consumer leaders experience frustration and become demoralized.
- Resiliency and recovery based services are not available as a result of not having Medicaid or employment.

Scope:

- Transform the current system (cross-agency) into a consumer and family driven mental health system with focus on individualized care plans, expanding network of supports and involvement in all aspects of system. Coordinate activities with other workgroups.
- Statewide and across agencies—i.e., entire system of care; think long term & short term.
- Culturally sensitive, trauma-informed, recovery/resiliency oriented and address the lifespan.
- Inventory of practice across the state will be completed.

Team Members:

- Director DMH Office of Consumer Affairs
- Consumer representative from an active Procovery Circle
- Family receiving services from a System of Care site
- Cross-divisional Consumer/Family representatives
- Family member of youth with dual diagnosis (MR/DD, ADA)
- Representatives from organizations who support family members, youth and consumers.
- Representative from COSP organization
- Family Peer Support Specialist/Parent Partner
- Youth coordinator
- DMH Divisions including Facility representatives, MIMH
- Other State Departments /Government Branches
- Provider Representatives
- Representative from the Program in Consumer Studies and Training at the Missouri Institute of Mental Health (Consultant)

Resources:

- Commitment of members time for meetings; estimated twice monthly for half day up to six months and periodic follow-up through year end
- Stipend and travel expense for consumer family workgroup participants who are not participating as part of regular job (all workgroups)
- DMH/MIMH staff support; support from Technology work group

Transformation Working Group
Team Charter
Disparities are Eliminated Workgroup

Current Situation

There is an inequitable distribution of services, supports and resources available to Missourians with behavioral health needs across the state. Service utilization of persons with mental health needs vary based upon certain demographic and geographic characteristics.

- Multiple funding streams for mental health services, with unique categorical regulations, exist across state and local agencies. Per capita state and federal mental health funding varies per region/service area as does private mental health services funding.
- There is minimal local investment in mental health. Only 14 counties (10%) have passed a mental health tax levy. Only 6 counties have passed a children's tax levy (<5%). Local infrastructures to support mental health vary across the state and are often uncoordinated with state and other local bodies.
- The DMH has a cultural competency plan and plan for deaf services that have not been fully implemented. Cultural and geographic barriers to appropriate services and community supports exist for minorities, rural populations and other populations such as the deaf and hard of hearing.
- Housing and job opportunities and supports for persons with mental health needs vary across Missouri communities.

Desired Outcomes

- Disparities in service and supports access, utilization and outcomes are eliminated.
- Workforce disparities are reduced/eliminated.
- Disparities resulting from co-occurring disorders are eliminated.
- State-local infrastructures support Missouri communities to identify and prioritize local mental health needs and efficiently develop and coordinate services and community supports at the local level.
- Public and private resources are maximized and coordinated to efficiently deliver community-based services and supports to meet local needs.
- Identification of desired state and local roles in planning, public education, service delivery and evaluation.
- Increase the range, availability of employment opportunities and the number of individuals holding full time jobs, experiencing workplace satisfaction, and retaining those jobs in their own communities.
- Increase the range and availability of housing options across the state and the number of persons living independently in their communities.

Undesired Outcomes

- Increased disparities
- Increased centralization /state operated services/FTE's
- Decreased mental health resources, employment and housing opportunities
- Increased fragmentation/turf battles

Scope:

- Review of financial/service/current local structures
- Life-span; recovery-oriented, trauma informed, culturally competent
- Review of current plans and requirements for implementation

- Regulatory review and financial analysis to identify gaps and barriers in services and community supports including employment and housing
- Involve state, local and private partners in rich dialogue
- Develop short-term and long-term recommendations

Team Members

- State Departments/Other State/Local Government Branches
- Consumer & Family Representatives
- DMH Divisions, including facility representative; other appropriate staff including Director of Deaf Services
- Local Public/Private Planning Boards /Funding Bodies
- Local Provider and Community Organizations
- Businesses (Chamber) representatives
- Representatives with expertise in workforce development
- Expertise in the Corrections Employment Networks
- Representatives with expertise in housing development

Resources

- Commitment of members' time for meetings; estimated twice monthly for half day up to six months and periodic follow-up through year end
- DMH/MIMH staff support; support from Technology work group

Transformation Working Group
Team Charter
Easy, Early Access Workgroup

Current Situation:

- The first contact for individuals to the public mental health system is often at a time of crisis and involves high end services such as emergency room, acute inpatient stay or via the potentially unnecessary involvement with other systems (i.e. – criminal justice, homeless services, juvenile justice, etc.)
- Primary care physicians, pediatricians, criminal justice, higher education counseling services, nursing homes, ob/gyn clinics and school systems rarely screen for or provide information about mental health issues when referral may possibly be indicated.
- Once the need for mental health services has been identified, it is often difficult for individuals to access mental health services.
- Stigma regarding mental health services can prevent individuals and health providers from being mindful and diligent in regard to mental health. Cultural factors can significantly enhance a reluctance to address mental health well being.
- There is a lack of understanding regarding mental health issues in children/youth and older adults/seniors.
- External systems are reluctant to refer for mental health needs because of lack of access/capacity to address identified mental health service needs.

Desired Outcomes:

- This team must plan to take Missouri from fragmentation to appropriate consultation, collaboration and integration at the local level.
- Protocols for implementing identification and early intervention for mental health needs are adopted through local planning processes and owned by the local health care, school, criminal justice and other critical early identification systems at the local level.
- Flexible protocols that facilitate screening, when indicated, by primary care physicians, pediatricians, schools and criminal justice providing early identification of mental health service needs across the life span.
- Mental health needs of individuals/families are identified and addressed before they become mental health crisis.
- System capacity for mental health services is adequate to meet the need generated through early identification of need for services.
- Trained/educated natural community supports are available to assist in addressing behavioral health needs.
- Culturally rooted reluctance to seeking mental health services when needed is significantly reduced due to employment of culturally competent and effective strategies.
- Explicit capacity to measure service system access.
- Potential partnerships with continuing education programs to facilitate knowledge of mental health issues and resources.

Undesired Outcomes:

- Early identification procedures and service access requirements that are difficult, complicated and burdensome resulting in lack of use and diminished benefit.
- The identification of the need for services without a plan for building system capacity to actually provide such services.
- Over-identification of need for public sector mental health services without sound justification.
- Over-use of screening when not indicated by symptoms/self-report.

Scope:

- Statewide and across all systems of care, coordinate with other workgroups (e.g. reducing stigma barriers, local system development)
- Assess current public/private system capacity and barriers to access
- Broad parameters and guidelines to promote consistency across regions and local communities should be provided and process development and implementation rooted in the local planning processes.
- Appropriate identification and early intervention should occur across the lifespan and within natural settings.
- Protocols/procedures must be culturally competent, trauma informed, consumer centered and recovery oriented.
- Technology to support desired outcomes.
- Diversion strategy protocols including criminal justice (crisis intervention teams, jail diversion, mental health courts, and correction system re-entry) and custody diversion in the children's system.
- Identify local natural supports and their role in addressing behavioral health service needs.

Team Members:

- Appropriate DMH staff (clinical director, prevention director, MRDD director of autism & children's services, CSMT, others)
- Public Administrator representation.
- School representation
- DMH Divisions including facility representatives, MIMH
- Other State Departments/Government Branches
- Fiscal/budget representative
- Consumer and Family representatives
- Provider and Community Organization representatives

Resources:

- Commitment of members' time for meetings; estimated twice monthly for half day up to six months and periodic follow-up through year end
- DMH/MIMH staff support; support from Technology work group
- Research what is already in existence and the depth of utilization
- Identify opportunities to build on "lessons learned" from other states or jurisdictions

Transformation Working Group
Team Charter
Evidence-Based Practice Workgroup

Current Situation

- There is no current consensus on the definitions of Evidence Based Practices (EBP) in Missouri.
- While precursor practices to EBP exist in MO, and some likely approach fidelity, there has been no systematic systems inventory to determine the extent of implementation.
- Understanding of the content and value of EBP is variable in the state.
- Training for staff on EBP's has been limited.
- Policies, certification standards, and funding streams currently do not support adoption of EBP's.
- While a number of academic researchers interface with DMH and other agencies around the delivery of mental health services, systematic efforts to implement, disseminate, and/or investigate EBP's through collaborative research partners are inadequate.
- Certain valued practices, most particularly Procovery and Peer Delivered Services are being mindfully supported and studied in order to bridge "Service to Science."

Desired Outcomes

- Shared understanding of the concept of research "evidence" as it relates to mental health practices. Stakeholders will understand that some practices have a more robust evidence base than others.
- An inventory of existing EBP's throughout the state.
- An analysis of gaps in the delivery of EBP's.
- Broad stakeholder understanding and support of EBP achieved through consensus building and values clarification at the local level.
- Implementation plans for filling gaps in the delivery of EBP's, including plans for workforce development.
- Development of policies, certification standards, and funding sources to support the delivery of EBP's.
- The development of subgroups or connections to already existing groups focused on the implementation of specific EBP's (e.g., Co-SIG grant; supported employment initiative, etc.).
- Development of university collaborations around the implementation and evaluation of EBP's including a heavy emphasis on fidelity assessment and outcome evaluation.
- Congruence with DMH Certification Requirements
- Consumers throughout the state of Missouri will have access to Evidence Based Practices.
- The identification of promising practices to be studied and evaluated as potential EBP's (i.e., *service to science*), will continue.
- Prioritized implementation plan for specific EBP's (which ones)
- Proposed infrastructure to support EBP implementation

Undesired Outcomes

- Maintenance of the status quo—i.e., limited adoption of EBP's.
- Non-Evidence Based Practices are labeled Evidence Based
- Inability to develop the infrastructure, policies, and/or funding streams to foster implementation of EBP's.
- The need for significant budget increases to support EBP implementation.
- Disparities in the availability of EBP's.
- Inability to sustain EBP's post MH Transformation Grant.

Scope

- Statewide and across agencies—i.e., entire system of care; think short and long-term.
- Culturally sensitive, trauma-informed, recovery/resiliency oriented and address the lifespan
- Inventory of practices across the state will be completed
- Development of infrastructure proposal for bridging science and service gap

Team Members

- Clinical Director, Division of Comprehensive Psychiatric Services, Missouri DMH
- Clinical Director, Children, Youth, and Families, Missouri DMH
- Representatives from universities with expertise in research and workforce development
- Representatives with expertise in treating dually diagnosed individuals
- DMH Divisions including facility representatives, MIMH
- Other State Departments /Government Branches
- Consumer and Family representatives
- Provider Organization representatives
- State Advisory Council representative

Resources

- Co-Occurring Disorders Grant, other related EBP grants/resources
- Commitment of members' time for meetings; estimated twice monthly for half day up to six months and periodic follow-up through year end
- DMH/MIMH staff support; support from technology workgroup.

Transformation Working Group
Team Charter
Technology Workgroup

Current Situation

- Consumers and families have stated that "speed and access to the system" is crucial, and that information about services and availability is a major need when access scarce resources.
- DMH has revised its service and reimbursement policies to support psychiatric telemedicine to close gaps in rural areas. The need exists to expand this practice across populations and agencies to support access to care.
- Many consumers require cross-departmental services, however, each state agency maintains its own client data base. Fragmented data systems do not support evaluation and planning activities. A children's data warehouse is planned and in the development stages to begin to address these issues.
- Electronic health records are not widely available.
- Technology advancements for data analytics and risk prediction factors are promising when combined with good service practices.
- People do not know how to access/use tools to facilitate communications.

Desired Outcomes

- Improved efficiency and effectiveness of services through the use of technology
- Improved communication through the use of technology
- Access to relevant data for effective planning and evaluation at all levels of system
- Increase capacity to extract meaning from data

Undesired Outcomes

- Complexity that decreases involvement
- DMH-only ownership of the project
- Unauthorized access to consumer information
- Inefficient use of existing funding and resources
- Gathering data that isn't used and not using relevant data that is available
- Not sharing data between agencies

Scope

- Statewide and across agencies—i.e., entire system of care; think short and long-term.
- Strategically supports other workgroup goals and recommendations. Coordinate efforts with other agency initiatives.
- Phase one scope will require workgroup member organizational meeting and then subgroup designated participation on other workgroups. Phase two will require technology workgroup integration and planning based upon phase one requirements identified.
- Supports consumers in self-directing care.
- Culturally sensitive, trauma-informed, recovery/resiliency oriented and address the lifespan.
- Inventory of existing resources and practices across the state will be completed.

Team Members

- Information Technology Services Department-Office of Administration/DMH
- DMH Director of Data Analytics
- DMH Data Analytics representative
- Representative(s) with expertise in tele-health and network of care technology
- DMH Divisions including Facility representatives, MIMH

- Other State Departments /Government Branches
- Consumer and Family Representatives
- Provider Organization Representatives

Resources

- Commitment of members' time for meetings; estimated twice monthly for half day up to six months and periodic follow-up through year end.
- Representation from technology workgroup will be assigned to participate in other workgroups during phase one.
- DMH/MIMH staff support